CHAPTER 8 — CLAIM PROCESS

800 Filing an ICI Claim

The following steps comprise the ICI claim filing process:

1. Employer instructs the disabled employee to call the third party administrator to file a claim. (See Subchapter 104 for contact information.) The employer should provide a blank *Income Continuation Insurance Claim Form* (ET-5352) to employees wishing to file a paper claim. (See Subchapter 807 for a sample document.) Paper claims must be mailed to the Department of Employee Trust Funds (ETF). Filing claims by telephone is recommended as it reduces paperwork and eliminates delays associated with mailing claim forms to ETF.

   A claim should be filed within one month of the date total disability begins or as soon thereafter as is reasonably possible. No benefits are payable more than 90 days retroactively from the date the claim is received by the third party administrator (or ETF if a paper claim is filed). Claims received more than 12 months from the first date of disability (as determined by the third party administrator) will be denied.

2. The third party administrator's customer service representative collects basic information from the claimant including name, Social Security number, date of birth, and current mailing address.

3. The claimant provides related information to the third party administrator such as the nature of the disability, last day worked, contact information for their attending and/or treating physician, and any additional work-related information.

4. The third party administrator mails the claimant an introductory letter, a medical release form, and a letter to be given to their physician.

   - The claimant introductory letter explains how the program works and what to expect while the claim is pending.

   - The claimant must sign the medical release form and immediately return it to either the third party administrator or the claimant's attending and/or treating physician.

> **NOTE**: The attending and/or treating physician, clinic, and medical records departments will not release confidential medical information to the claim administrator without the claimant's consent. Until that release is given, the claim cannot be processed. The claimant is responsible for the cost of medical records and exams.

801 Employer Information Required by the Third Party Administrator

The third party administrator sends an *Income Continuation Insurance (ICI) Employer Statement* (ET-5351) to the employer via e-mail if an e-mail address is available. (See Subchapter 806 for a sample document.) The form is mailed if the employer does not have an e-mail address on file. The claimant's name, Social Security number, employer seven-digit EIN (starting with the 69-036-) and employer name will be pre-filled on the form by the third party administrator. The employer statement requires the employer to complete the following information:

a. Employee's occupation (Title) – also indicate employment type (e.g. permanent).
b. Last day worked – Last day physically on the job.
c. Last day paid – Last day for which earnings were paid for vacation, sick leave, holiday or compensatory time (not the date of their final check).
d. Salary (Locals: monthly salary only):
   - For employees who worked the entire previous calendar year, report the total earnings paid to the employee during the previous calendar year rounded to the next higher thousand and divided by 12;
     OR
     For employees who did not work the entire previous calendar year (new employee) or resumed covered service after an interruption extending 3 consecutive months or more, report the current year's projected salary used to adjust premiums on March 1.
   - Indicate whether the employee is full or part-time. If part-time, indicate the percentage of full-time.
e. Indicate the following Worker's Compensation information:
   - Whether or not a claim has been filed and, if so, if it has been denied or is still pending.
   - Worker's Compensation effective date and paid through date.
   - Weekly Worker's Compensation amount.

f. (State Only) Leave this area blank.
g. (State Only) Leave this area blank.
h. Premium Category/Elimination Period - Indicate the selected elimination period for the year in which the disability began (current year) as well as for the previous three calendar years.
i. (UW –Faculty Only) Leave this area blank.
j. (Locals Only) Elimination Period-Calendar Days - Circle the number of calendar days 30, 60, 90, 120, or 180 for the current selected elimination period.
k. Date through which premiums are paid. - Include the current date for which premiums are paid.
l. (Locals Only) Percentage of premium paid by employer in prior years. Enter the percentage of premium paid in effect at the end of the calendar year.
m. (Local employers leave this area blank.)
(State Only) Claimant Has Elected To:
n. Employer - Circle "Local" and indicate employer name.
o. Authorized Employee Signature - The authorized designated representative certifies that the information on the form is correct.
p. Employer contact and e-mail address - The third party administrator will send approval, denial and termination notices via e-mail.

Note: Continue collecting ICI premiums until notified of the claim determination. After completion of form ET-5351, please make a copy for your records. The completed form and a copy of the employee's current position description should be returned to ETF, P. O. Box 7931, Madison WI 53707-7931 or fax to (608) 267-0633.

802 Third Party Administrator Claim Review

The third party administrator reviews ICI disability claims in the following manner:

- A registered nurse, hired by the third party administrator, calls the attending and/or treating physician to obtain clinical information concerning the claimant's disability.

- The nurse may call the physician to arrange a return to work plan for the claimant. The plan may include modified hours or restricted duties. The third party administrator contacts the employer to determine whether job modifications can be made. The claimant receives written correspondence from the third party administrator regarding any determinations.

- The third party administrator contacts the physician for ongoing review of the disability claim to obtain updates on symptoms, diagnosis, treatment and the return to work plan.

- Prior to the claimant's return to work date, the third party administrator may call to confirm the claimant's return to work plans if, at the last medical update, the physician did not indicate the possibility of an extension of the individual's claim.

803 Approval, Denial or Termination Notice

The third party administrator notifies the employer of the claim's approval or denial via e-mail or U.S. mail. The notice indicates whether ICI premiums will be waived or if the individual will be required to continue paying the premium.

The employer will also be notified when the claim is terminated. The termination notice provides the date that ICI premiums resume. (See Subchapter 808 for a sample document.)

The claimant has the right to request, in writing, reconsideration of the third party administrator's approval, denial, termination or other benefit determination. The third party administrator must receive the written request and any additional information no later than ninety (90) days after the date of the initial benefit determination letter. The request for reconsideration must indicate the issues with which the claimant disagrees and provide any additional information they would like considered as part of the review. The third party administrator is required to respond to the employee's request for reconsideration within ninety (90) days of the claimant's request for reconsideration or the receipt of the additional information, whichever is later.

Following receipt of the claim administrator's reconsideration decision, the employee has the right to submit a written request to ETF for a Departmental Determination of the decision. The written request must be received by ETF no later than ninety (90) days from the claim administrator's reconsideration decision letter. The employee can provide any additional information they would like included in ETF's review. ETF reviews all requests in the order of date received. Any additional medical information not previously provided to the claim administrator will be forwarded to the claim administrator's medical staff for review.

In the event the employee remains dissatisfied following ETF's determination, they have the right to submit a written request for an appeal of ETF's determination before the Group Insurance Board (GIB). The request for appeal to the GIB must be received by ETF's Appeals Coordinator no later than ninety (90) days of the date of ETF's Department's determination letter.

804 Waiver of Premium

ICI premiums are waived effective the first of the month on or after the date ICI benefits began. The premium waiver remains in effect through the end of the month in which ICI benefits are terminated. Do not assume premiums are waived until notified by the third party administrator of the ICI claim approval.

805 *Income Continuation Insurance Claim Form* (ET-5352)

Department of Employee Trust Funds
INCOME CONTINUATION INSURANCE CLAIM FORM
Wis. Stat. § 40.61 and 40.62

SEE BACK FOR INSTRUCTIONS–PRINT IN BLACK INK

			Social Security Number
Name (Last, First, Middle, Maiden)		☐ Male ☐ Female	Birthdate (MM/DD/CCYY)
Occupation (Title)/Classification	Employer/Agency		Division/Location
What is the nature of your disability? Describe complications, if any.			
Last Day Worked	First Date Disabled	Date First Treated	Expected Return to Work Date

Name of Attending Physician	Complete Address (Street, City, State, Zip Code) & Telephone No.	Specialty	Dates of Care (MM/DD/CCYY)
Names of Other Health Care Providers Treating You	Complete Address (Street, City, State, Zip Code) & Telephone No.	Specialty	Dates of Care (MM/DD/CCYY)

Have you applied for any of the following benefits or do you have other employment? An applicant for ICI benefits must take all necessary action to obtain and assign any other benefits available. Notify ICI if any other benefits/source of income become payable.

Yes	No		Yes	No	
☐	☐	Wisconsin Retirement System	☐	☐	Social Security Administration
☐	☐	LTDI	☐	☐	Unemployment Compensation
☐	☐	Worker's Compensation	☐	☐	Other Plan or Other Employment (specify)

I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims, and hereby certify that, to the best of my knowledge and belief, the above information is true and correct. I hereby authorize any and all physicians, hospitals, clinics, State and Federal Agencies, the Social Security Administration, etc., to release to the Income Continuation Insurance Program third party administrator Broadspire and/or the State Department of Employee Trust Funds information from my health, rehabilitation, employment, Worker's Compensation, Unemployment Compensation or Social Security records. I understand the specific type of information to be released includes any and all medical and/or treatment records, and may include records pertaining to alcohol abuse, drug abuse, records with reference to child abuse, developmental disabilities, mental illness, HTLV-III (AIDS) testing and results, and/or treatment records. This release is being made for the purpose of determining eligibility for disability benefits. A copy of this authorization shall be considered as effective and valid as the original and shall be valid for the duration of the claim, but not to exceed one year from the date signed.

Signature of Claimant	Date Signed (MM/DD/CCYY)	Telephone Number ( )
Claimant's Address (Street, P. O. Box, City, State and Zip Code)		

ADMIN. USE

Employer Number	☐ Prior Claim ☐ Cov. via EOI–Approval Date _____
	Name Then (if different) _____
Taxable Percentage	Normal Retirement Age _____ Protective Category NRA _____
_____ %	Biweekly Benefit Amt. $_____ Monthly $_____
	Date Disability Begins _____ Benefits Begin _____

ET-5352 (REV 09/2004) **Mail to: ETF, PO BOX 7931, MADISON WI 53707-7931**

806 *ICI Employer Statement* (ET-5351)

Department of Employee Trust Funds

INCOME CONTINUATION INSURANCE (ICI) EMPLOYER STATEMENT

Wis. Stat. § 40.61 and 40.62

Employee Name
Social Security Number
Employer Identification Number

INSTRUCTIONS TO EMPLOYER:
The employee named below is applying for an ICI benefit. Please follow the detailed instructions on the back of this form and return it to ETF promptly. Benefits cannot be computed until this form is received and processed.

Occupation (Title)	Last Day Worked *(MM/DD/CCYY)*	Last Day Paid *(MM/DD/CCYY)*
☐ Seasonal/Academic Yr ☐ LTE ☐ Permanent ☐ Project ☐ Per Diem		

Salary (Locals: monthly salary only) ☐ Biweekly ☐ Monthly ☐ Full Time ☐ Part Time	Has claim been filed for Worker's Comp? ☐ Yes ☐ No ☐ Denied ☐ Pending	Worker's Comp. Effective Date _____ Paid Thru _____	Weekly Worker's Comp Amount
$ Part Time Percent _____%			$_____

(State Only) Total Sick Leave Shown to hundredths of an hour–2 Decimal Places	(State Only) Date Sick Leave is Exhausted *(MM/DD/CCYY)*	Premium Category/Elimination Period			
Accumulated Hrs _____ Earned Hours _____ Total Hours _____		Year _____	Year _____	Year _____	Current Year

(UW-Faculty Only) Elimination Period- Calendar Days	(Locals Only) Elimination Period-Calendar Days	Premiums are Paid Through *(MM/DD/CCYY)*
30 90 125 180	30 60 90 120 180	

(Locals Only) Percentage of Premium Paid by Employer in Prior Years:

20_____ %	20_____ %	20_____ %	Current Year %

(State Only) Claimant Has Elected To:
☐ Use a Max. of 130 Days of Sick Leave ☐ Bank All Sick Leave After:_____(MM/DD/CCYY)

Employer *(Circle: State or Local)* Division *(State)* Central Payroll Code Number *(State)*

I understand Wis. Stat. § 943.395 provides penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct.

Date *(MM/DD/CCYY)*	Authorized Employer Signature

Employer contact e-mail address:	Employer Telephone No.

Date Sent to Employer:	Sent by:	Telephone Number:

ET-5351 (REV 07/2004) **Mail to: ETF, PO BOX 7931, MADISON 53707-7931**
FAX: 608/267-4549

807 ICI Claim Approval Notice

«TodaysDate»

«ClaimantsFirstName» «ClaimantsLastName»
«CLAddress1» «CLAddress2»
«CLCity», «ClaimState» «CLZip»

Re: [State or Local] Income Continuation Insurance (ICI) Plan
EIN: [STATE ER]
Social Security # «SSN»

Dear «ClaimantsFirstName» «ClaimantsLastName»:

Your claim for ICI benefits has been approved based on the following:

Disability Begin Date:	«CLDisabilityDate»
[Elimination Period or Sick Leave] is completed:	DATE
Benefit Begin Date:	«CLBenefitBeginDate»
Premium Waiver Effective Date:	DATE
Date of First Check: MAILED 2 DAYS PRIOR	[JAN-MAY] [JUN-DEC]
Period of Time Covered by First Check:	DATE
Amount of First Check:	$AMOUNT

Your Benefit is PERCENTAGE taxable. You [Will/Will Not] receive a W-2.

The ICI plan provides 75% of your gross basic earnings, as defined in the ICI plan. The amount of your benefit and first check was computed as indicated at the end of this letter. We suggest you save this letter for future reference.

Your ICI benefit checks will be issued the first of each month for the previous month. For example, the benefit for February will be issued March 1st. You will need to allow the U.S. Post Office time to deliver your paper checks. A stop payment on a paper check cannot be issued until 12 days after the date of the check.

ICI benefits are reduced by the gross amount of any disability, retirement, separation, or other income replacement benefits that are paid or payable from other State, Federal or Employer sponsored sources. You must apply and complete the application process for all benefits that you may be eligible to receive. ICI benefits will be reduced by the largest benefit you could receive from another source, even though you fail to apply, fail to complete the application process, or choose an option that pays a reduced benefit. Other benefit sources include, but are not limited to:

- Worker's Compensation
- Unemployment Compensation
- Social Security (regular retirement, disability or Supplemental Security Income (SSI)

- Wisconsin Retirement System (WRS) (retirement, disability retirement, duty disability)
- Long-term Disability Insurance (LTDI, or separation, including lump sums)

Any benefits you have received after your benefit begin date or which you may receive in the future will reduce your ICI benefits. For example, if you received a retroactive benefit from the Social Security Administration, which covers a time period for which you have already received ICI benefits, your ICI benefits will be reduced (offset) by the Social Security benefit. **Your ICI claim will be overpaid and you will be required to repay the duplicated benefits to the ICI program.**

Please contact Broadspire immediately if you:

- Return or are released by your physician to return to full or part-time work (previous or any other employer, including self-employment)
- Apply for or received benefits from any other source
- Must extend the expected duration of your disability
- Are no longer disabled

Pursuant to § 2.21 (5) of the ICI plan, you have the right to request reconsideration of this benefit determination by Broadspire, but your written request must be received by Broadspire no later than 90 days after the date of this letter. You may provide any additional information you believe is relevant to your request for reconsideration, but it also must be received by Broadspire no later than 90 days after the date of this letter.

To request reconsideration, send a letter outlining the reason(s) you feel the benefit determination was in error to:

Broadspire
200 Wheeler Road
Burlington, MA 01803

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

Sincerely,

Broadspire

cc: Department of Employee Trust Funds (DETF)
[EMPLOYER'S NAME]

(100)

FIRST BENEFIT CHECK CALCULATION		
		Gross Monthly
	75%	
$	-	ICI Gross Monthly Benefit
	30	Days
$	-	Daily ICI Benefit

TAXABLE INCOME		
Taxable Income %		0%
Taxable Income	$	-
Daily ICI Benefit	$	-
Number of Benefit Days		0
Gross Initial ICI Benefit	$	-
Less State Tax	$	-
Less Federal Tax**	$	-
Less F.I.C.A.	$	-
Less F.I.C.A.	$	-
First Payment Amount	$	-

* The daily benefit is payable for each day that you are continuously disabled, including weekends and holidays.

** The taxable portion of your benefit is withheld at the rate of 25%. For additional information about taxable benefits, please refer to Taxable Benefits in the ICI booklet. If you wish to change the amount of Federal Tax withheld, you may submit form W-4S to Broadspire. This form is available through the Department of Treasury, Internal Revenue Service. WI State Income Tax will only be withheld from a taxable benefit if you submit a WI Withholding Exemption form, WT-4, to Broadspire. It is available from the WI State Department of Revenue.

808 ICI Claim Denial Notice

«TodaysDate» **Certified Mail # Receipt Number**

«ClaimantsFirstName» «ClaimantsLastName»
«CLAddress1»
«CLAddress2»
«CLCity», «ClaimState» «CLZip»

Re: Income Continuation Insurance (ICI) Disability Benefits
Social Security # «SSN»

Dear «ClaimantsFirstName» «ClaimantsLastName»:

Broadspire has reviewed your request for Income Continuation Insurance (ICI) benefits and cannot approve your request for the following reason(s):

- **[REASONS]**

Optional Reason; delete this line, if not applicable. You did not remain completely off work or be totally disabled from your own occupation for the minimum elimination period of 30 calendar days.

Optional Reason for Voc Rehab; delete this line, if not applicable. A Vocational Rehabilitation Review has deemed you capable of performing other substantial gainful employment for which you are reasonably experienced and educationally qualified.

Optional Reason for Elimination Period; delete this line, if not applicable. You did not remain completely off work and be totally disabled from your own occupation for the elimination period of 30 Days.

No objective medical information to substantiate your disability.

[Insert Reasons Here] or [Optional Paragraph]: Any Occupation

Your disability benefits have been denied effective [DATE].

RIGHT OF ADMINISTRATIVE REVIEW: If you disagree with the decision made in regard to your claim, you may request a reconsideration review through Broadspire. Your request must be made in writing and received by Broadspire within ninety (90) days of the date of this letter. Please send your request to:

Broadspire
200 Wheeler Road
Burlington, Massachusetts 01803

Your request must outline the reason you feel the decision was made in error.

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

Thank you.

Broadspire

cc: Department of Employee Trust Funds (ETF)

ICI Claim Denial/Closure

«TodaysDate»

[EMPLOYER]
ATTENTION: [ATTN: NAME]
[Address 1]
[City, State, and Zip]

Re: Income Continuation Insurance (ICI) Disability Benefits

Dear [Employer]:

The Income Continuation Insurance claim for the following Employee has been [terminated/closed].

NAME OF EMPLOYEE:	«ClaimantsFirstName» «ClaimantsLastName»
SOCIAL SECURITY NUMBER:	«SSN»
PAID THROUGH:	

CLAIM TERMINATION BECAUSE:

NO LONGER DISABLED AS OF:	
RETURN TO WORK ON:	
OTHER:	

Further action is not anticipated. Resume premium payment effective [DATE].

If you have any questions, please call Broadspire at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

Sincerely,

Broadspire

cc: Department of Employee Trust Funds (ETF)